Permission to share Personal Medical/Financial Information

Emergency Contact Name: _____

Relationship to Patient: _____

Phone #: _____

I give my permission to Arlington Family Chiropractic Clinic, (Dr. Kurt Price and/or staff) to share my personal medical information including but not limited to diagnosis, treatment plan and prognosis with the person(s) listed below. I also give Arlington Family Chiropractic Clinic (Dr. Kurt Price and/or staff) permission to share any financial information with the person(s) listed below as may be appropriate.

Persons allowed access to your personal health/financial information:

1. _____
2. _____
3. _____

Print Patient Name: _____

Signature of Patient/Guardian: _____

Witness: _____

Date: _____